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Report to Congressional Requesters

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INDIAN HEALTH SERVICE

Funding Based on Historical Patterns, Not Need

With appropriations totalling approximately $1.2 billion in fiscal year 1990, IHS administers its programs through 12 geographically defined IHS area offices. Health services are provided directly by 50 IHS hospitals and about 150 outpatient health centers. The CHS program purchases other services not accessible or available through IHS facilities from private or public providers.[3] IHS does not attempt to provide the same level of health services in all IHS areas; in fact, services vary widely.[4]

Under current regulations, to be eligible for IHS services, a person must be of Indian descent and live in an area served by IHS facilities. In recent years, IHS has not been successful in attempts to reduce the number eligible to use its services. In 1986, IHS proposed new eligibility regulations that would have required one-quarter Indian blood, among other criteria, to qualify for IHS services. This proposal was interpreted by many tribes as a possible threat to tribal sovereignty. As a consequence, IHS dropped the Indian blood requirement from the final September 1987 regulations. The additional proposed eligibility criteria have not been implemented because the Congress has restricted the use of appropriated funds for this purpose, pending further examination.

The one-quarter Indian blood requirement would have reduced eligibility for IHS services proportionately more in Oklahoma than IHS-wide. This is because the Oklahoma area, which has the largest number of Indians eligible for IHS services, also has the largest share of Indians with less than one-quarter Indian blood. Data from IHS's patient registration system suggest that nearly 40 percent of Oklahoma Indians have less than one-quarter Indian blood, compared with an average 14 percent in that category throughout IHS.

[3]IHS also provides preventive health services not discussed in this report, including sanitation, public health nursing, health education, community health representatives, and immunizations.

[4]IHS is not a federal health entitlement program, like Medicare, but must operate within its annual appropriation from the Congress. IHS regulations state that IHS will provide services only to the extent that funds and resources allocated to a particular IHS area permit.

Historical Funding Patterns Leave Area Distributions Unchanged

Oklahoma's relative share of total IHS funding has not increased significantly since 1980 because IHS continues to allocate most funds on the basis of previous-year funding. Attempts by IHS to distribute more funds by formulas that incorporate measures of Indian health status and resource needs have met with limited success.

The distribution of funding and services among the 12 IHS areas is based primarily on past funding history, not on Indian population size, health status, or resource needs. Under this allocation method, each IHS area's base budget is equivalent to its base budget from the previous year and a share of IHS annual funding increases proportional to the area's share of the total base. Thus, increasing funds to one area reduces funds available to other areas. IHS officials said that redistribution of base allocations could be disruptive to ongoing programs.

Funding for all IHS area office programs and services (excluding headquarters operations) increased from approximately $517 million in fiscal year 1980 to about $1 billion in 1990 (see app. II). During that period, Oklahoma's funding increased from $59.9 million to $131 million, but remained at about 12 to 13 percent of total IHS area funding.

Only a Fraction of Funding Has Been Distributed Based on Need

IHS's methods of distributing funds among the 12 service areas have been under debate for many years. This has been especially true since 1980, when a federal court found disparities in area funding and directed IHS to take steps to reduce them.[5] The Congress established an IHS equity fund for this purpose, and IHS developed funding formulas that incorporated data on area resource needs. Due principally to funding availability, however, these methods have been applied to relatively small amounts of money. Between 1980 and 1990, IHS distributed only 2 percent of its total funding—about $187 million—using the needs-based methods described below. As a result, needs-based funding has had relatively little effect on the overall funding picture.

Although there have been variations in the needs-based funding formulas IHS has used since 1980, in general they reflect area health resource deficiencies and Indian health status. The first formula was used to distribute $32.4 million in equity funds earmarked by the Congress in fiscal years 1981 through 1984 (see app. III for a summary of needs-based funding since 1980). In the mid-1980s, IHS refined its equity formula by developing a needs-based resource allocation methodology

[5]Rincon Band of Mission Indians vs. Califano (1980).

(RAM). IHS applied RAM to approximately $120.6 million in special purpose funding between 1985 and 1989. In 1987, however, IHS also used RAM to redistribute 2 percent of base funding for hospitals and clinics. IHS area officials and tribes protested such redistributions. As a result, in 1988 the Congress amended the Indian Health Care Improvement Act (P.L. 100-713) to prohibit the reduction of 5 percent or more of the funding for any recurring program, project, or activity of an IHS service unit without prior submission of a report to the Congress. This amendment, among other things, (1) authorized a new Indian Health Care Improvement Fund and (2) established a methodology, known as the Health Services Priority System, for distributing that fund. IHS applied the priority system for the first time in fiscal year 1990, but it was used to distribute less than $10 million earmarked for the fund out of the $1 billion available to the areas. An additional $24.5 million was allocated by RAM-based formulas in 1990.

Increased Needs-Based Funding for Oklahoma Has Not Increased Overall Share

The Oklahoma area has received a relatively large share of the IHS funds distributed under needs-based formulas, but the area's share of overall funding has not changed greatly.

Oklahoma received a total of $32.6 million, about 17 percent, of the $187 million distributed by IHS needs-based formulas since 1980. Oklahoma's share of this special funding is somewhat larger than its share of total IHS funds (12 to 13 percent). The relatively small dollar amounts of special funding have not significantly increased total funding for Oklahoma, however, and have barely increased Oklahoma's per capita funding position relative to the IHS average. This was so even in 1990, when the Oklahoma area received nearly 30 percent of all funds distributed by needs-based formulas, including $4.5 million of the $10 million Indian Health Care Improvement Fund.

Per Capita Funding for Oklahoma Indians Relatively Low

Per capita IHS funding for Oklahoma Indians is low relative to average per capita funding throughout IHS: Oklahoma's per capita of $597 in 1990 for the user population is about 60 percent of the IHS average of $1,014.[6] The Oklahoma area has about 20 percent of IHS's service population and 22 percent of its users, but receives only 12 to 13 percent of

[6]These per capita figures are based on IHS user population estimates, rather than eligible population estimates, and therefore can be compared with the results of the Oklahoma Inter-Tribal Council's analysis. IHS applies user population estimates in its needs-based resource allocation formulas. Using IHS eligible service population estimates, Oklahoma's 1990 per capita of about $605 is nearly 65 percent of the IHS average of $932 per capita.

total funding. There are differing opinions, however, about whether per capita funding is an appropriate measure of the reasonableness of area allocations.

The issue of per capita funding was raised in a report published in March 1989 by the Inter-Tribal Council of the Five Civilized Tribes of Oklahoma.[7] This analysis of fiscal year 1988 funding and 1987 user population data from IHS showed that Oklahoma, the area with the largest Indian population, ranked lowest among the 12 IHS areas in combined per capita funding for hospitals, clinics, and CHS services.[8]

Our analysis of IHS funding and user population estimates for fiscal years 1989 and 1990 (see app. IV) confirms that per capita funding for Indians in the Oklahoma area is roughly 55 to 60 percent of the IHS average. In 1990, Oklahoma's funding for hospitals, clinics, and CHS services combined amounted to about $537 per capita compared with $910 for all IHS areas.

Per capita funding is relatively low in Oklahoma, IHS headquarters and Oklahoma area officials explained, because (1) Oklahoma's large Indian population continues to grow and (2) more Indians who are eligible for IHS services may be using them instead of other sources of care. The second reason is the most important. The decline in Oklahoma's economy since 1980 has increased unemployment and caused some Indians to lose private health insurance. Many of these eligible Indians, after losing private insurance, have turned to IHS.[9]

However, the low per capita funding for Oklahoma Indians, some IHS officials said, does not necessarily mean that they are being treated unfairly relative to Indians in other IHS areas. The director of IHS has acknowledged that "IHS programs in the State of Oklahoma are severely

[7]The report, Status of Indian Health Service Funding in Oklahoma, was prepared by the Chickasaw Nation Office of Public Affairs for the Inter-Tribal Council of the Five Civilized Tribes, revised March 1989.

[8]The report calculated that Oklahoma received $379 per capita funding for these budget categories in 1988, compared with an IHS-wide average of $688 and a high of $1,2567 in one IHS area. IHS estimates that in 1989, average per capita health expenditures for all U.S. civilians was $1,823, which is more than twice the comparable IHS figure.

[9]IHS estimates that in 1989, nearly 220,000 Oklahoma Indians were active users of IHS services. Because of data limitations—data for estimating active users have become available only since initiation of a patient registry system in 1984—user estimates cannot be compared with IHS's estimated eligible Indian population figures. The estimated number of IHS-eligible Indians in Oklahoma has increased somewhat less rapidly than the total IHS eligible population, including newly recognized tribes, since 1980.

underfunded."[10] However, officials believe that Oklahoma Indians receive more health services from the IHS system and from private providers in their communities than do Indians on reservations in other areas. Moreover, IHS data show that the health status of Oklahoma Indians is better than the IHS average.[11]

IHS Service Delivery Strained in Oklahoma

The large number of Oklahoma Indians using IHS services is creating service delivery problems: we found evidence of strain in IHS outpatient services and CHS services. Some Oklahoma IHS hospitals and health centers were experiencing substantial increases in demand for outpatient services. Along with other IHS areas, the Oklahoma CHS program used a medical priority system to deny and defer large numbers of needed services.

Demand Exceeds Capacity for Outpatient Services

IHS officials told us that the Oklahoma direct care system has a large number of relatively new facilities (7 hospitals and 27 health centers) and good staffing.[12] But the demand for outpatient and emergency services is outstripping capacity, even though facilities appear sufficient to meet Oklahoma Indians' need for inpatient care.[13]

Oklahoma is not the only IHS area that has experienced a growing demand for services in recent years. Nonetheless, we found that Oklahoma's Claremore and Tahlequah service areas, for example, each provided inpatient or outpatient services to between 300 and 500 new patients per month during 1989. Their hospital outpatient departments were operating above capacity, and there were 9-month to 12-month waiting lists for routine outpatient appointments late in the year. Emergency department use also had reached overflow proportions.

[10]Everett Rhoades, M.D., Director, IHS, letter to Governor Henry Bellmon of Oklahoma (May 12, 1990).

[11]A recent IHS report indicated that in 1987, the age-adjusted mortality rate (all causes of death) for all Indians living in IHS service areas was 663.0 deaths per 100,000 population, compared with a rate of 535.5 per 100,000 for U.S. residents of all races. For Oklahoma Indians alone, the rate of 495.3 was lower than for all races, but underreporting of Indian deaths in Oklahoma accounts in part for this low rate.

[12]IHS officials told us that Oklahoma Indians are more likely to have both geographic and financial access (through private insurance) to private health services than Indians in some other IHS areas. Available data, however, are not adequate to support or refute this point.

[13]Utilization data for Oklahoma facilities indicate that inpatient occupancy did not exceed 65 percent in any of the hospitals in 1989 and inpatient days had declined slightly (by 5.7 percent) since 1985. Numbers of outpatient visits, however, increased by 26 percent from 1985 to 1989.

Contract Health Services Rationed

The CHS program spends about one-fifth of IHS's total clinical services budget to purchase, from private providers, services that are inaccessible or unavailable in IHS facilities. For example, CHS may purchase heart and orthopedic surgery, diagnostic procedures that require special equipment, and services of physician specialists not on IHS staff.

IHS has developed a system of medical priorities for determining which needed CHS services should be authorized and paid first when funding is not adequate to pay for all. In recent years, demand for contract services has exceeded CHS program funding in Oklahoma and other IHS areas. In 1990, all area CHS programs were directed to limit services to these priorities: (1) emergency and urgent care for life-threatening conditions and (2) urgent treatment to prevent further deterioration in conditions. As a result, eligible Indians have not been authorized to receive other needed services that do not meet these priorities.

Within the medical priority criteria, IHS area offices are responsible for deciding what services to purchase and managing their own annual CHS budgets. In Oklahoma, area administrative and medical staff review each CHS service request to ensure that (1) only top-priority services—primarily those necessary for life-threatening conditions—are authorized and (2) these services are only for Indians who lack any other source of payment.

IHS administrators in the areas have cut CHS services in two ways. First, CHS programs throughout IHS reported that they denied payment for almost 79,000 services already obtained by IHS-eligible Indians from private providers during fiscal year 1989. More than 27,000 of those denied services (about 35 percent) were in Oklahoma. Payment on claims was denied, even for about 4,000 high-priority CHS services throughout IHS, because of lack of funds; 3,786 of those services (94 percent) were reported from Oklahoma.[14]

Second, many CHS services are deferred, that is, not authorized for delivery or payment by IHS at the time of request, even though the patient is an eligible Indian with no other source of payment. Deferred services may be authorized later if funds become available, or patients

[14]IHS officials question the CHS denial figures because of differences among the areas in the completeness and accuracy of data reporting. The medical priority guidelines, in particular, may be applied inconsistently because of the individual patient circumstances and medical judgment involved. IHS's chief medical officer reviewed 600 of the 3,786 high priority CHS services denied in Oklahoma in 1989. Although he did not agree that all services were high priority denials, he concluded that Oklahoma is denying payment for more CHS services than other areas.

may not receive the services at all. At the end of fiscal year 1989, CHS programs in all IHS areas had a backlog of more than 32,200 deferred services that could not be authorized within existing medical priority criteria and budget constraints. One-third (10,638) of the deferred services in 1989 were reported for IHS-eligible Oklahoma Indians. A special fund of $4.9 million was distributed among the IHS areas in fiscal year 1990 to help cover this backlog of deferred CHS services. The RAM-based formula gave Oklahoma $955,400 (19 percent) of the fund.

Conclusions

IHS's current funding distribution methods do not take into account variations in an area's Indian population size, health status, or resource needs; thus, these methods allow at least the perception of funding inequities. However, given less than full funding for the overall IHS system, any change in the allocation system will result in some areas getting more funds and others getting less. In the past, IHS has experienced strong opposition to change from areas facing reduction. Consequently, IHS has had limited success in redistributing funds.

Matters for Congressional Consideration

If the Congress wants IHS to redistribute funding among the areas, the Congress should consider requiring IHS to distribute its funds based on different methods, for example, methods that give greater weight to measures of need.

We discussed the contents of this report with IHS officials, incorporating their comments where appropriate. As arranged with your office, unless you publicly announce its contents, we plan no further distribution of this report until 5 days from its issuance date. At that time, copies will be sent to the appropriate Senate and House Committees and Subcommittees; the Secretary of HHS; and the Director, Office of Management and Budget. We will make copies available to other interested parties on request.

If you or your staff have any questions about this report, please call me on (202) 275-6195. Other major contributors are listed in appendix V.

Sincerely yours,

Mark V. Nadel

Mark V. Nadel
Associate Director for National
and Public Health Issues

Contents

Appendix V
Major Contributors to This Report

Abbreviations

CHS	contract health services
HHS	U.S. Department of Health and Human Services
IHS	Indian Health Service
RAM	resource allocation methodology

Scope and Methodology

Following discussions with your congressional offices, we limited our work to the Oklahoma IHS area and focused on developments since 1980. We reviewed documents and interviewed officials at IHS headquarters in Rockville, Maryland, and the IHS Oklahoma City Area Office. In Oklahoma, we also met with representatives of Oklahoma Indian tribes.

We relied on IHS funding, population, and service use data provided by IHS headquarters and the Oklahoma office. In some cases, we were unable to verify the accuracy and completeness of data reporting. In addition, there are reporting variations among the 12 IHS areas.

Our review was carried out from January through July 1990 in accordance with generally accepted government auditing standards. We discussed the matters in this report with IHS officials and have incorporated their comments where appropriate.

IHS Funding Allocations to 12 Areas (Fiscal Years 1980-90)

Dollars in thousands

Fiscal year	Total IHS allocations to 12 areas[a]	Allocations to Oklahoma IHS area	
			In percent
1980	$516,625	$59,873	11.6
1981	576,600	69,942	12.1
1982	591,496	73,314	12.4
1983	655,020	79,801	12.2
1984	742,599	94,843	12.8
1985	762,659	98,540	12.9
1986	770,007	99,093	12.9
1987	809,709	104,470	12.9
1988	859,466	109,136	12.7
1989	930,231	115,380	12.4
1990	1,026,851	131,035	12.8

[a]Allocations to areas are the amounts of IHS's annual appropriations distributed to 12 IHS area offices. Area allocations total less than the full appropriations because of funds retained by IHS headquarters for headquarters operations, special initiatives, and program reserves.

IHS Allocations by Various Needs-Based Formulas Including Allocations to Oklahoma IHS Area (Fiscal Years 1980-90)

Type allocation and fiscal year	Total amounts allocated to areas	Allocations to Oklahoma IHS area	In percent
Equity funds, fiscal years 1981-84[a]	$32,362,000	$4,620,000	14.3
IHS allocations using RAM and RAM-based formulas, fiscal years 1985-89[b]	120,594,000	17,827,000	14.8
Health Services Priority System and RAM-based formula allocations,[c] fiscal year 1990	34,377,200	10,103,200	29.4
Total	**$187,333,200**	**$32,550,200**	**17.4**

[a]The Congress appropriated equity funds totalling $32,362,000 in fiscal years 1981-84.

[b]IHS allocations using the resource allocation methodology (RAM) include some special funds in 1984 and 1985.

[c]Fiscal year 1990 funds reflect reductions because of sequestration.

Per Capita Funding: Average for All 12 IHS Areas and for Oklahoma IHS Area Only (Fiscal Years 1989-90)

Fiscal year 1989 allocation	All IHS areas including Oklahoma		Oklahoma IHS area	
	Total	Per capita[a]	Total	Per capita[b]
Total allocation[c]	$930,231,000	$919.98	$115,380,000	$504.59
Clinical services allocation[d]	$826,351,700	$817.25	$102,613,300	$448.75
Fiscal year 1990 allocation				
Total allocation[c]	$1,026,851,300	$1,014.49	$131,035,000	$596.66
Clinical services allocation[e]	$920,953,800	$909.87	$118,009,100	$537.34

Note: Clinical services category includes hospitals and clinics; CHS; dental, mental health, and alcohol services; and facility maintenance and repairs; excludes preventive and other services.

[a]Our estimates are based on IHS final user population estimates for all areas of 1,011,142 in 1988 for the 1989 per capita figure; and 1,012,186 in 1989 for the 1990 per capita figure. The most recent available user population figures are for 1989.

[b]Our estimates are based on IHS final user population estimates for the Oklahoma area of 228,663 in 1988 and 219,616 in 1989.

[c]See appendix II for total allocations to areas and to Oklahoma.

[d]IHS Office of Administration and Management, fiscal year 1989 area allocations by category.

[e]IHS Office of Administration and Management, fiscal year 1990 area allocations by category.

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